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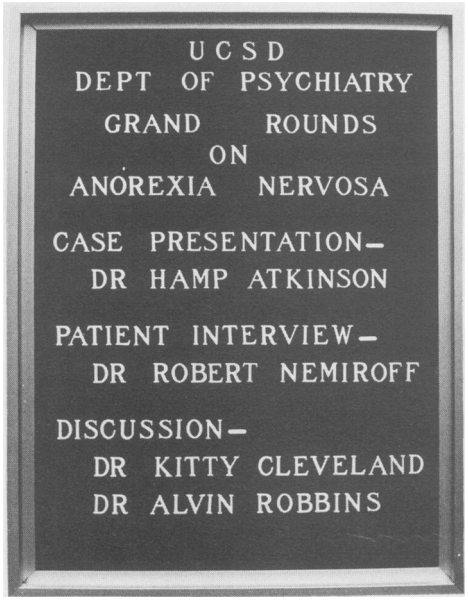

Anorexia Nervosa

Based on Psychiatric Grand Rounds held at the San Diego Veterans Administration Hospital, a teaching facility of the School of Medicine, University of California, San Diego, in October 1973; edited by Barbara Blomgren, BA, and Leighton Huey, MD.

DR. ATKINSON:* The patient is a 41-year-old divorced, unemployed clerk who entered the hospital complaining, "I was unable to take care of myself." She was born in Chicago, lived in Sweden from the age of one to the age of six, and then returned to California to live permanently. The patient has a long history of depression and associated weight loss, beginning at the age of 15 when, during several months of absence from her father, her weight dropped from 115 to 90 pounds. At the time she rejoined her father her weight increased rapidly, to a maximum of 135 pounds at the age of 18. During that first period of weight loss she became amenorrheic. Menstruation resumed between the ages of 17 and 21, at which time she again became ameorrheic, and she has remained so. In adolescence she had few if any dates, secondary to her mother's insistent sexual prohibitions. When she was 19 years old, she left home to join the Air Force, and a year later she married an Air Force officer. After three months the marriage was annulled at her mother's insistence, and from the age of 20 the patient lived in the parental home. She found employment and did well as a clerk and stenographer.

At the age of 20 she began using 10 to 12 dextroamphetamine sulfate (Dexedrine®) tablets daily for fatigue and depression and continued this for 14 years. She said she had not used amphetamine since 1966. For the last 20 years her weight had varied between 75 and 90 pounds, with one all-time low of 58 pounds when she was 34 years old. Around the age of 24 she had a three-month episode of depression and a weight loss of 20 pounds. She was admitted to hospital and after an upper gastrointestinal series and barium enema she was told that her weight loss was due to emotional problems. There was no psychiatric follow-up. She then did reasonably well until, seven years before the present admission, she suffered severe depression, rectal prolapse secondary to laxative abuse, lost weight to 58 pounds, and was admitted to hospital to gain weight. At the end of two months in the hospital she had regained almost all of her lost weight, but after discharge she began to have vomiting after every meal, which continued to the present admission.

About four years ago her father died of carcinoma of the stomach, and she gave up her job to devote full time to the care of her invalid mother. In 1971, the patient had resection of a malignant melanoma. Two years before admission she became increasingly depressed because

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of her mother's illness, and she attempted suicide by chloral hydrate overdose in her mother's presence. She was admitted to hospital and there was diagnosed as having passive-aggressive personality disorder. She was treated with imipramine hydrochloride (Tofranil®), 75 mg per day. Her mother died of multiple cardiovascular accidents shortly after the patient's suicide attempt. A few months later the patient re-entered the hospital with complaints of depression. She was diagnosed as an emotionally unstable personality, treated with thioridazine (Mellaril®), 100 mg per day, and discharged to outpatient follow-up at a community mental health center. During the next year she was followed with monthly group therapy and treated with diazepam (Valium®) and amitriptyline hydrochloride (Elavil®) in psychotherapeutic amounts.

Her appetite remained satisfactory until about nine months before admission when she became increasingly depressed and anorectic, possibly secondary to problems with her boy friend and her female roommate. Four months ago, she entered our outpatient clinic because of depression and weight loss. She was seen in individual psychotherapy and treated with doxepin hydrochloride (Sinequan®), 150 mg per day. Despite treatment she lost 20 pounds during the next four months. One month ago, results of a complete endocrinological workup (including growth hormone, follicle-stimulating hormone, leutinizing hormone, and cortisol) were within normal limits, as were results of skull and upper gastrointestinal x-ray studies. Two weeks before admission she experienced indistinct auditory hallucinations; she said her mother cried over and over again to her, "Eat, eat!" She began interpreting noises from the air conditioning as voices from a crowd of people. Her outpatient therapist recommended admission to hospital because of the persistent weight loss and severe depression.

Her family history is significant in that she describes her childhood as relatively happy, but says her father was an alcoholic who was passive and distant and her mother was dominant and controlling. A maternal aunt suffered from affective disorder and killed herself.

On admission to hospital, the patient, who was 5 feet 3 inches tall and weighed 66 pounds, was thought to have a unipolar depression and possible anorexia nervosa. We began giving her Elavil, 200 mg per day, and undertook a behavior modification program linking progressive inpatient privileges to weight gain. The depression cleared rapidly, and she gained 13 pounds during the first five weeks in hospital. On the ward she was hostile, dependent and manipulative, voicing numerous somatic complaints. One episode of self-induced vomiting was witnessed by the staff and denied by the patient. We presume that she induced the other episodes of vomiting in the hospital, as she probably did the ones she describes having had after every meal for seven years.

She is being seen by two therapists simultaneously; administrative and therapeutic functions are assigned to different persons because of her continuous manipulative behavior. She really was unable to care for herself, unable to express her feelings and unable to see herself as an effectual person. Accordingly, during therapy we are making every effort to include her as an active member of the team in planning her treatment, and to get her to recognize her emotions, to express them, and to feel more significant as a human being. I think we have been moderately successful.

DR. LOWELL STORMS:* The patient was given psychological tests two days after admission to hospital. A Minnesota Multiphasic Personality Inventory (MMPI) showed severe depression, marked anxiety, ruminations, low self-confidence, and a tendency to shyness and social withdrawal. There was also evidence of considerable character disorder, with passive-aggressive and passive-dependent features. She tends to be self defeating and have poor persistence and motivation. She has difficulty delaying the relief of anxiety and tends to rationalize her hostility and externalize it. She seeks dependent and immature relationships with men toward whom she might play a daughter role. There is evidence of vulnerability to problems with drugs or alcohol. The evidence suggests that she could become disorganized under stress and might be a borderline schizophrenic.

(The patient, whom we shall call Louise Jackson, was escorted into the room and introduced to Dr. Nemiroff, who interviewed her before approximately 100 staff members and residents.)

DR. NEMIROFF:† Hi, Louise. Would you have a seat here? Let me see if I can help you with the microphone — please excuse our technology. Thank you very much for coming here today,

*Lowell Storms, PhD, Professor of Psychiatry.

†Robert Nemiroff, MD, Assistant Clinical Professor of Psychiatry.

Louise. How do you feel about meeting here in front of this large group?

Patient: I don't really know, but I see some faces I recognize.

DR. NEMIROFF: You do?

Patient: Um hum.

DR. NEMIROFF: So you don't feel so all alone?

Patient: No.

DR. NEMIROFF: You're not. We're here with you. Louise, we've heard from Dr. Atkinson a little bit about some of the problems you've been having in the past and currently. But we were hoping to hear from you, in your own words, your understanding of the difficulties you have and what brought you to the hospital. Could you tell us?

Patient: Oh, I don't really know. Could you just ask me questions? I could say yes or no. To start with anyway.

DR. NEMIROFF: What didn't you know about my question?

Patient: Well, it was clear, but I didn't know where to start. It's kind of a long, drawn-out thing.

DR. NEMIROFF: I see.

Patient: It's something that's happened to me before.

DR. NEMIROFF: Uh huh.

Patient: But this time it really got bad, and I became very frightened.

DR. NEMIROFF: This time it became particularly bad, and you got frightened.

Patient: Yeah.

DR. NEMIROFF: Maybe that's a place to start. If you can tell us a little bit about exactly what happened right before you came to the hospital, and how it was bad for you and how you got frightened, that would be a way in which we could get into this a little bit.

Patient: Well, I have a roommate that's had very high blood pressure, and she wasn't feeling too well. She was in bed most of the time. And then I practically lost so much weight I didn't have any strength left, so I was in bed most of the time too. And between the two of us we didn't do any cooking to speak of, and I wasn't too hungry anyway, and I was having trouble retaining my food. I know Kathy Porter [the outpatient therapist] knows a little bit about it because I was coming here as an outpatient to see her. And she arranged it so I would be admitted here to the hospital.

DR. NEMIROFF: Well that's good. I'm glad that you came.

Patient: I am too. I was ready to leave, you know, the first week.

DR. NEMIROFF: You were?

Patient: I'm glad I stayed though. It's been very beneficial.

DR. NEMIROFF: Uh huh. What was it that was troubling you that first week? Why did you want to leave?

Patient: I thought there were too many restrictions, and I got kind of scared. I didn't know what I was getting into.

DR. NEMIROFF: Too many restrictions. People weren't letting you do what you wanted to do?

Patient: No. But I've acquired quite a few privileges now. I weighed 79 yesterday, and I weighed 80 this morning.

DR. NEMIROFF: Uh huh.

Patient: So I think that's going in the right direction.

DR. NEMIROFF: How do you see yourself at this point? On the thin side?

Patient: Yeah, I think so.

DR. NEMIROFF: How much weight do you think you need?

Patient: Well, I want to gain at least 10 more pounds before I leave the hospital. But there are other things that go along with that. I have to change my feelings about a lot of things—the reactions that I have—the way I meet people, and how I talk. Because I am kind of a shy person to begin with. Don't sound that way right now, though, do I?

DR. NEMIROFF: No, you're doing very nicely, and starting to express things a little bit, and I'm starting to get a better idea of things. I'd like to go back for a moment to the kind of thing that brought you into the hospital. You say you were there with your roommate, and there were the two of you there in the room, and she got sick.

Patient: Yeah, well she had high blood pressure, and she was in the process of getting the medicine changed, and it affected her so that she got dizzy every time she got up, and I was afraid she'd fall down or something, you know.

DR. NEMIROFF: I see. Sure.
Patient: So I was kind of worried about her.

DR. NEMIROFF: You were kind of taking care of her.
Patient: Well, we were taking care of each other, more or less. We didn't do a very good job of it, I'm afraid.

DR. NEMIROFF: I see. Uh huh. Did she do some of the cooking? Who did the cooking between the two of you?
Patient: Well, we ate more like cottage cheese and sandwiches. We both went to a restaurant, or like that. But I was living on instant breakfast that last week I was home. That was the only thing I could keep in my stomach. And I was afraid there might be something organically wrong, but there wasn't.

DR. NEMIROFF: Uh huh. What did you think might be organically wrong with you?
Patient: Well I had had a GI series, and the doctor did tell me that my stomach emptied a lot slower than other peoples', and I knew that I had to keep something in my stomach all the time, and the only thing that I could retain was that instant breakfast.

DR. NEMIROFF: What were some of your feelings when your roommate got sick?
Patient: Well, I was frightened for her, and one of the reasons we decided to move in together to begin with was the fact that she didn't want to live alone in her trailer, and I didn't want to live by myself, and I had no real home, so she just threw in her lot with me, financially.

DR. NEMIROFF: And then she couldn't keep up her end because she got sick and she took to bed and then you became upset with that. I see. That was a difficult situation because here you were depending on her and hoping that she would be a help, and yet she was depending on you.
Patient: Well, I realize now that the only person I can depend on is myself. I'm beginning to find that out more and more. And I know that when I get back home she'll be coming back with me, and she's been getting a lot better too since she's been gone, and she's been forcing herself to do more things, and I've been pretty busy here. There's a lot of things that I've had to do.

DR. NEMIROFF: How has your physical health been in general?
Patient: It's been good.

DR. NEMIROFF: Do you have any problems, or anything that concerns you?
Patient: No. No, I haven't had anything wrong with me.

DR. NEMIROFF: In the past?
Patient: Oh, in the past I've been hospitalized several times.

DR. NEMIROFF: For what?
Patient: Well, I had skin cancer once. And several times I've lost weight. And then I had rectal surgery in 1966. And I stayed quite a while in a hospital to gain weight before they did the operation on me. And then I went back there for another month and a half to recuperate.

DR. NEMIROFF: How are you doing with the skin cancer?
Patient: Oh, it was all taken out.

DR. NEMIROFF: It was all taken care of? That's not on your mind or troubling you?
Patient: No. I just have a big long scar down my back. No, I'm not worried about that at all. Since I've been here, you know, I haven't had any trouble with food or anything.

DR. NEMIROFF: Good.
Patient: So I'm working along pretty well.

DR. NEMIROFF: You like our cooking here?
Patient: Yeah. Yesterday I had four milkshakes.

DR. NEMIROFF: You know, Louise, we're talking about your current situation a little bit. I wonder if you and I could take a bit of a trip into the past? Is that all right?
Patient: How far back do you want to go?

DR. NEMIROFF: Let's go all the way back. Well, let's see. Let's at least go as far back as when you were 15 or so and you first started to have these difficulties. Could you tell me a little bit about that?
Patient: Well, my mother and I took a trip to Sweden, and we went over in the month of March, and the water was pretty rough, and the ship almost went down.

DR. NEMIROFF: Really?
Patient: Yes, three times—one side to the other—and the furniture and everything just got pulled loose from the floor.

DR. NEMIROFF: My gosh!
Patient: Yes, it was a real mess, and when I got

over to Sweden I got influenza real bad, and it was real cold over there and snowing, and I was homesick. I had just started high school, and my mother took me out of school to go over there, and the idea was that were were going to live over there, and that was worse yet. And we left my dad over here.

DR. NEMIROFF: I see.

Patient: And when we got over there my grandfather said, no, he didn't want us to stay there because he said I wasn't going to be happy there, and he didn't like the politics there, and it wasn't going to be very beneficial for us, and so mother and I had to come back. But I was really sick over there, and I started losing weight, and I also stopped my menstrual periods, and when we came back I was under a doctor's care for quite a while, and I think I was all right until about the time I joined the Air Force, and then I gained up to about 135 pounds. And then after I'd been working for about four or five years, I was down at X Hospital, and they couldn't find anything wrong with me. I had lost weight then. Oh, and then I've been in Y Hospital on the psychiatric ward a couple of times. A very unpleasant experience.

DR. NEMIROFF: What did you gather from those experiences?

Patient: I didn't get anything from them. Just that I didn't want to go back there again. Every time I lost weight I ended up back in the psychiatric ward. And yet the doctors there couldn't do anything for me.

DR. NEMIROFF: You didn't get any idea of the kinds of things that were troubling you, what it was that led you to come to the hospital?

Patient: No. When I was getting the psychiatric care, my mother and father were both alive, and they blamed all my problems onto my mother. And then when my mother died I got the blame for all the problems when it was, you know, extremely difficult. But I was never aware of that because my mother always took care of me and it wasn't that I wanted to lean on her so much but she wanted me home.

DR. NEMIROFF: She wanted you home. Could you tell me about that? Why was it she wanted you home?

Patient: Well, she thought I'd live better at home, and she thought I'd have more money to spend if I lived at home. And it turned out that I bought a new car every couple of years and had a nice wardrobe. I enjoyed having somebody taking care of me to that extent. She did all the cooking and everything, but it was what she wanted to do herself. She said, "The only pleasure I have is your own happiness." And that's always stayed with me. And when she became ill and I took care of her, well I was in a different kind of role, and I did the best for her that I could at that time. She was in a wheelchair for over a year, and she did die finally shortly after she was operated on. She had a fractured hip. They went ahead and operated a little too soon. I didn't think she was strong enough. And she died, and I was left alone, and that was really a loss. I was scared.

DR. NEMIROFF: I can imagine. What were you scared of?

Patient: I didn't know what was going to happen to me. My father had died two years before that time, and I had lost my mother. I had relatives that lived nearby, and they kind of took over for me—helped me out.

DR. NEMIROFF: You were very alone. What were you afraid was going to happen on your own?

Patient: Well, I don't know. I was kind of sheltered about so many things, you know. So, I don't know. I was kind of leery of a lot of things.

DR. NEMIROFF: In the way that she took over, you were kind of fed by her continually.

Patient: Yeah, only I didn't realize the damage that I was doing to myself. I've found that out now.

DR. NEMIROFF: You mean there were pros and cons? You had the security of being with her and being in that relationship and there were nice things about it, but you were kind of robbed and cheated of your own development?

Patient: Yeah. But, you see, nobody ever brought those things to the front before, so I didn't, you know, wasn't aware of them. But I'm aware of them now.

DR. NEMIROFF: Yeah, it seems to me you are working on it.

Patient: Yeah, at times.

DR. NEMIROFF: Um hum, you really are. You're working with Dr. Atkinson and the ward psychotherapy program. How do you feel about the therapy and what is happening?

Patient: Well, it's been good for me, and I know

that the doctors and nurses spend a lot more time with their patients and they get to know them, you know, in and out. And they can help a lot more that way.

DR. NEMIROFF: I think you are getting a lot of help. I want to go back, this is a little bit personal, but I want to go back to talking about your mother. She died . . . and you went to the funeral?

Patient: No, we had no funeral for her. My aunt made up her mind that we didn't need a funeral for her; she was going to be cremated.

DR. NEMIROFF: No service?

Patient: I had a memorial service for her afterwards.

DR. NEMIROFF: You arranged your own service for her?

Patient: Well, the minister out there said he would be glad to do it.

DR. NEMIROFF: Did you cry during that time?

Patient: No, I didn't cry then, but I sure have cried a lot since. I was just too thunderstruck at first, you know.

DR. NEMIROFF: Sure. Was it at the service that you felt too thunderstruck by being left alone, and you couldn't cry?

Patient: Yeah, I think so. I cried the day that she died, and then I really didn't shed too many tears, but I've shed plenty since.

DR. NEMIROFF: Do you think about her frequently?

Patient: Not as much as I used to.

DR. NEMIROFF: What would you think about when you would think about her a lot?

Patient: I always visualized her the way she was before she died. She was in this hospital bed, and she had her leg in traction; she couldn't talk, and her hair was, you know, wrapped around her head, and she just didn't open her eyes and recognize me or anything else. I tried to squeeze her hand, and there just wasn't any return.

DR. NEMIROFF: So you remember those last days when it was difficult to get in touch with her.

Patient: If I could just see her the way she was before, you know, it would be all right, but I just get this vision of her the way she was when she died.

DR. NEMIROFF: That may be something to work on, getting in touch with those previous memories. How about your dad? I understand he died before your mother did.

Patient: He died in 1969, yes. He had cancer of the stomach. He was up at the Z VA Hospital.

DR. NEMIROFF: Uh huh. He was at the Z VA Hospital. Did you visit him there?

Patient: Yeah.

DR. NEMIROFF: And could you tell me a little bit about his funeral? Did he have a funeral?

Patient: Yeah, well, we didn't have any graveside service for him. He was cremated too. But we had a chapel service for him, and the VFW showed up in full force, but uh, I could never go and look at him in the funeral room.

DR. NEMIROFF: You didn't want to do that. Why not?

Patient: I didn't want to see him then. I'd never seen anybody before that was dead.

DR. NEMIROFF: I see. Did you cry during his service? Were you able to?

Patient: I don't remember. Some things don't stand out too clearly for me.

DR. NEMIROFF: Do you ever dream of your mother and father?

Patient: Oh, yes. I do.

DR. NEMIROFF: Uh huh. What do you dream of?

Patient: Well, I've had various dreams about them. One time I had a very shocking dream. I dreamed that my mother had the mind of a five-year-old. And that frightened me. I woke up crying that morning. It happened here in the hospital. I think that was the worst dream I've ever had.

DR. NEMIROFF: What frightened you about it?

Patient: The fact that she couldn't speak out or act like she had really done.

DR. NEMIROFF: Um hum—that she was helpless and actually couldn't be of help, theoretically couldn't be of help to you. Louise, I have one more very brief question. It's also of a personal nature, and this is going back to when you were 15. Sometimes some problems around that age come up when people have concerns about sexual matters of different sorts, and I was wondering whether you remember anything about that and how you feel about that.

Patient: My mother always sheltered me. She did too good a job of sheltering me, because the

idea of sex is frightening to me to a certain extent. I was brainwashed very well when I was young.

DR. NEMIROFF: I see. Could you just give me a notion of that brainwashing?

Patient: Well, she always told me that sex was something that happened between two people and was for the woman to become pregnant and have children.

DR. NEMIROFF: I see. Well, maybe that's something you can go into with Dr. Atkinson and understand a little bit more. We have to stop in a moment or two. Is there anything about your hospitalization or the interview this morning that you'd like to ask me or anyone here about?

Patient: Well, I probably can't think of anything right now, but the minute I leave the room I'll probably think of about five or six things.

DR. NEMIROFF: Great! Good! That means that we've had a good time this morning and we worked on things successfully if you do think of those five or six things. And I want you to remember every one of them and ask your doctor, OK? Is that a promise?

Patient: OK.

DR. NEMIROFF: You did really well this morning, and thank you so much for coming in.

Patient: Thank you for having me.

DR. NEMIROFF: Good Luck, Louise.

(The patient was escorted from the room.)

MS. KATHLEEN PORTER:* In the months I saw Mrs. Jackson in the outpatient clinic I tried to use Bruch's[1] model to deal with her feelings of total ineffectuality in terms of her emotions and the way she dealt with the people in her life. She did pretty well with that. In nearly four months she lost only about 10 pounds. Then her roommate got sicker, and (this is my analysis of it) they got involved in a game about who could be the sicker. I saw this as a replay of the situation with her mother: "Who is going to meet whose needs?" She lost 10 pounds in the two and a half weeks before admission.

DR. NEMIROFF: Was she in touch with her feelings about the roommate getting sick and having to care for the roommate, and having needs herself that weren't being met?

MS. PORTER: She was totally out of touch with how she felt about anything. She couldn't tell Dr. Atkinson or me about how angry she was at us about the behavior modification program we tried on the ward. Now she is able to say that she didn't like the restrictions and was angry, but at the time she only acted it out.

DR. NEMIROFF: I was impressed with the fact that she is now able to say a few angry things about her mother—to say that she feels her mother cheated her.

MS. PORTER: She's really getting more in touch with how she feels about that and about us, more able to identify her angry feelings. We've been trying to help her be more accurate and honest in expressing her feelings. The nurses on the ward also tell her when she is communicating effectively and when she's not.

DR. ROBBINS:† The first thing I'd like to say about anorexia nervosa is that it isn't a disease. It's a syndrome that is found in several different disease entities—unlike psychological malnutrition, which occurs in catatonic schizophrenia, mental retardation, schizophrenic decompensation or hunger strikes. For many years the standard text has been a book by Bliss and Branch.[2] Their definition of anorexia nervosa is "any psychologically determined weight loss of 25 pounds in a prescribed period of time." To me this is too inclusive; I prefer to describe anorexia nervosa as a syndrome in which there is emaciation and weight loss characterized by a psychologically determined reduction in nutritional intake.

The age of onset is puberty or post-puberty adolescence. More than 90 percent of anorectic patients are female. There is usually spontaneous or self-induced vomiting. There is almost always amenorrhea, as well as constipation, with excessive use of laxatives. Such patients are usually full of energy and even hyperactive, quite the opposite of what you would expect in someone that malnourished. Often there is not a real loss of appetite; hunger is defended against. In some instances there is poor awareness of hunger. Other fairly common behaviors in anorectic patients are stealing (often of food), a pre-occupation with food (gathering recipes, memorizing menus), and extreme sexual inhibition. Additional physical symptoms include decreased body temperature, heart rate, respiratory rate, and basal metabolism rate. The 17 ketosteroids are either normal or elevated,

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†Alvin Robbins, MD, Assistant Clinical Professor of Psychiatry.

the opposite of what you might expect. The nails are brittle, and the teeth often loose. Occasionally you see avitaminosis and edema. In the later phases, with the cachexia, there is the onset of intercurrent illness, like tuberculosis or pneumonia, which is often fatal.

The two major authors to whom I would refer you are Mara Selvini Palazzoli[3] and Brunhilde Bruch.[1] They write of two kinds of anorexia nervosa. The atypical kind involves a situation in which the food itself has symbolic meaning; for example, oral impregnation and other hysterical fantasies. Other atypical cases might involve the inhibition of envy and jealousy, in which the prohibition of food is a way of dealing with envy, oral greed, and the like. Food may be seen as poison by severely paranoid patients and be refused simply because to eat it would be fatal.

The psychogenesis of typical or primary anorexia nervosa involves early and severe disruption of mother-child object ties, and the rejection of food is a defensive attempt to maintain identity and separation from a destructive, intrusive mother. Obviously a child's relationship to mother is geared around food. Mother and food are often equated when a child hasn't the ability to distinguish between them, and in the phase in which the child is developing independence and autonomy there is often a hassle about eating habits. Moreover, this often comes up during toilet training, and the constipation, enemas, laxatives and manipulative behavior are also part of it.

In Palazzoli's description of the psychogenesis, typically the mother is aggressive, hyperprotective, and incapable of considering the daughter a person in her own right. Her feeding of the infant is ritualized and controlled. In the daughter's childhood the mother interferes, criticizes, takes over vital experiences and prevents her daughter from feeling like her own person. All spontaneous and unique experiences are disqualified. It's almost as if the mother takes control of the girl's body and directs it, and what the girl is left with is something inside that body, her self. A split occurs between body and self: "My body belongs to mother; my self belongs to me." Here we have Bruch's ideas of conceptual and perceptual distortion in bodily image and Palazzoli's idea of bodily mistrust.

The onset of adolescence is often accompanied by feelings of helplessness and unreality. Sometimes depression, which decreases the appetite, brings attention to food, and may provide the nidus for the defense. Struggles against being captive, invaded, and exploited, with no life of her own, are the *sine qua non* of the anorectic patient. Starving gives her a sense of identity, control, and effectiveness. Her feeling is that the body, which is equated with the bad object, mother, would be overpowering if it were nourished. The body is a thing that grows at the expense of the person, and the struggle is to be a person, not a thing. The primitive quality of the object relationship is obvious. It isn't surprising that on MMPI's and especially on Rorschach tests most of these patients fall under the rubric of core schizophrenic.

Frequently the underlying cause of the anorexia is discovered to be severe affective disorder. In many instances the anorexia nervosa seems to be a defense against schizophrenia on the one hand and severe depression on the other. The body is something between "not me" and "bad me." If the defense works the absolute schizophrenic break is avoided because projection doesn't occur onto some other object but onto one's own body. Anorexia can avoid depression and suicide because the body needn't be destroyed as long as it is kept in check. I guess it is irrelevant whether or not you accept this theory of the dynamics. The point is: don't deal with this as a disease entity unto itself; understand that it is a series of defenses against severe ruptures in object relationships.

The patient presented today has a classic history. Her mother is described as insistent, controlling, demanding and intermittently loving. She restricted the patient's dating and sexual activity, even had her marriage annulled. The patient lived with her mother because mother decided it was best for her. We have the history of the onset of the problem in adolescence, with the absence of father, who I imagine was seen as a benign figure with whom the patient might ally against the mother. The chloral hydrate ingestion doesn't seem like a serious suicide attempt; with the mother right there it seems more like an expression of anger. Louise's long history of difficulty with object relationships, her repeated hospitalizations, and the results of her psychological testing indicate serious underlying depressive disorder.

Freedman and Kaplan[4] describe psychotic depressive reaction this way: sadness, energy depletion, weight loss, constipation, sleep disturbance, headaches, delusions of sin, guilt, and unworthiness, occasional suicidal thoughts, paranoid features, auditory hallucinations and hypochondria-

sis. It all fits. I see this patient's anorexia nervosa as a defense against her early aberrant object relationships, depression and psychosis. The problems that have occurred on the ward seem to repeat the early problems with her mother. She struggles for control to achieve some identity. She attaches herself to protective males on the ward, as she may have tried to do with her father to protect herself from her intrusive mother. The staff on the ward are saying EAT! She can understand intellectually that she's starving herself, but she needs *not* to eat to maintain a sense of identity. I think the therapeutic-administrative split fits right into her defense, and I suspect she made this split between good object and bad object absolutely necessary. As therapists you're in a double bind: you want her to eat because if she doesn't she's going to die—but if you insist that she eat you're repeating the earlier experience with her mother. So what do you do? I can mention what's been tried elsewhere.

If there were some hormonal deficit it was once thought that hormone therapy would take care of the anorexia. There wasn't, and it didn't. Insulin has been tried to stimulate hunger, but the results were equivocal. Chlorpromazine has been used. Electroconvulsive therapy (ECT) has been tried. Supportive therapy and analytic therapy have been successful occasionally. Behavioral therapy has been used to some advantage. Albert Stunkard[5] at the University of Pennslyvania focuses on the hypomanic, hyperactive quality in the anorectic patient. For every half pound gained per day he gives a patient a six-hour pass outside the hospital. Apparently this works in some cases. He's also tried giving such patients chlorpromazine hydrochloride (Thorazine®), which they hate because it slows them down, then decreasing the dose for increments in weight gain. The point is that in any behavioral therapy you have to find some wedge with the patient, something she wants.

I think any form of treatment stands a greater chance of success if you pay attention to the underlying cause of the anorexia nervosa. One treatment is going to look better than another only if it is more appropriate for the underlying illness involved. In this case I would suggest that the therapeutic-administrative split is not indicated because Louise needs to learn that the person saying EAT can also be non-invasive and non-destructive. This might be easier to learn from one person. The chances are that this patient will regain weight, go back out, find some other problem, and get herself back into the hospital. At that point I would recommend a trial of phenothiazine or antidepressant medication, and if that didn't work I would consider electroconvulsive therapy because I see her problem as an underlyng psychotic depressive reaction.

DR. DANIEL KRIPKE:* I agree that the risk of future episodes in this patient is enormous. A recent article by Prien et al[6] shows that both lithium and imipramine were effective in preventing depression. Perhaps she would benefit from either a tricyclic antidepressant or lithium to combat future episodes.

DR. LEIGHTON HUEY:† I can't be entirely complacent about viewing this as a syndrome and not a disease. Endocrinologists have been trying to document it as a disease entity, focusing on the fact that amenorrhea frequently precedes the onset of weight loss. They may yet find that we are dealing here with some malfunction of the hypothalamic pituitary axis.

DR. ROBBINS: Some cases we now call anorexia nervosa might have endocrinologic bases, but in many others every attempt to find hormonal deficits or organic difficulties has yielded nothing.

DR. CLEVELAND:‡ What interests me most is how you treat a patient who comes in weighing 60 pounds, won't eat and rejects all therapeutic attempts. When a patient is medically in danger from her anorexia, you have to *do* something. Thoma[7] has achieved good initial weight gain with tube feeding and high doses of chlorpromazine. He uses psychotherapy only when the patient is almost up to normal weight, if at all. Dally and Sargant[8] have successfully treated a series of patients with a combination of chlorpromazine and insulin in the acute stage, followed by a great deal of psychotherapy. Tec[9] has reported that nandrolone, an anabolic steroid, helped ten of twelve anorectic patients he treated during the last decade. Benady[10] has reported that cyproheptadine hydrochloride (Periactin®) has increased weight gain in a couple of patients, although I can't explain an antihistamine's having this effect either. It is obvious that the medical approach has its limits. You can keep a tube down only so long, and you can use, say, chlorpromazine only so long

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because a lot of these patients rebel against sedation.

The behavior modifiers steer away from medical treatment if they can, but what they do varies a great deal. Some of them have tried deconditioning patients who have an apparent phobia of food or eating, with fairly good effects on initial weight gain, but there are no good long follow-ups. In the follow-ups of five of Stunkard's patients I found that one committed suicide, and two continued very poor social adjustment; I wasn't impressed with those long-term results.

Laboucarie and Barres[11] have published a study of 39 patients with whom they tried ECT and achieved variable results. These were not psychotic patients, and I suspect that the efficacy of the treatment was related to the underlying cause of their anorexia, as Dr. Robbins has suggested.

In my opinion the best long-term treatment is psychotherapy. Most people agree that the classic analytic approach does not work with anorectic patients. Even Thoma,[7] who has an analytic orientation, says you have to form a very good alliance with the patient initially. In other words, you throw away the analytic handbook until you have the patient's confidence. Bruch[1] emphasizes that you must make the patient participate. You can't sit there interpreting, telling her what she feels. You must allow her to make her own interpretations, to come into contact with her own feelings, or hunger, or anxiety, and to realize that they originate in her body and are a part of her, not something imposed on her by the outside, mothering, figure.

DR. IGOR GRANT:* At Pennsylvania we noticed that anorectic patients often had distorted bodily images of themselves. At one time Dr. Stunkard had large mirrors on the ward, and he would say to a patient, "Please describe yourself." Amazingly, even the most emaciated patients would say, "Well, my breasts are a little bit too big. I have a little bit too much fat here on my hips." Also, I would like to underscore the statement that many of these patients really are not aware of their internal states, especially their hunger. This fits with the dynamic factor Dr. Robbins spoke of —the situation in which the mother has usurped the function of the child's internal sensing apparatus. I suspect there are similar factors in the background of some obese patients, who also don't seem well attuned to their inner states.

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The therapy at Pennsylvania was broader, I think, than the impression we have so far today. Dr. Stunkard avoided saying EAT by gearing the contract to weight gain and specific things that the patient obviously wanted. How the patient gained weight was in a sense immaterial—eating was not mentioned. Too, the antidepressants and phenothiazines were used differentially for patients who were thought to be primarily depressed or primarily schizophrenic. This regimen did work well in the hospital, but the patients tended to decompensate after discharge. When I left, family therapy was being tried in the treatment of younger patients.

DR. KENNETH MINKOFF:† When I was in Philadelphia I had a chance to observe a couple of sessions of that family therapy. The initial goal of the therapist was to intercede between the mother and daughter so that they were forced to relate to each other through him. Then he told the girl that she had to do without food completely to control her anorexia. She became negativistic about this prohibition, and began to demand food. He forbade any food except dry toast initially. Then she begged, increasingly frantically, and in the process expressed a lot of her angry feelings. Gradually he let her add items to her diet. Eventually he was able, quite casually, to tell her she could eat anything she wished.

DR. DANIEL BRUMFIELD:‡ I had the opportunity to test a 19-year-old anorectic girl on the bicycle aerodometer. Although she stood 5 feet 6 inches and weighted 89 pounds, she worked at loads at which the average girl or 40-year-old businessman would work, and she tolerated them much better. Her blood pressure rose less; her pulse rate rose less; and her recovery was fantastic. Her subjective experience was less troubled. I was impressed with how well she functioned and how good she looked.

DR. MINKOFF: I recall that some of Stunkard's patients registered up to 10 miles a day on the pedometers he had attached to their ankles. As they got better, the amount of activity decreased.

DR. GRANT: In view of all that energy, you need to be careful in designing your behavioral modification paradigm—gearing it to something like miles per day would be better than gearing it to something easily achieved.

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DR. ROBBINS: This reminds me of a 12-year-old anorectic boy described to me by a local analyst several years ago. The boy had various neurotic fantasies and made a great to-do about food and recipes, but he wouldn't eat. In desperation the analyst took the boy's bicycle away, and the anorexia was cured almost immediately.

DR. HUEY: What about the sex distribution—the nine to one split?

DR. ROBBINS: If, as in the formulation I gave, the body were seen as separate from the self, as belonging to the mother, when a girl entered puberty and became physically like her mother, the bodily introject would fit, and the perceived need to defend the self against it would be reinforced. Boys would not experience this kind of reinforcement at puberty. The anorectic boy I described had oral impregnation fantasies that occurred around puberty and the birth of a sibling. No single dynamic factor has been established, although Bruch[1] does address the problem.

DR. NEMIROFF: It seems to me that in our contacts with an anorectic patient we need to avoid the power struggle that comes out of the background. Whether we use drugs, or behavior modification, or psychotherapy with the individual or her family, we need to work toward a therapeutic alliance with the hope of getting to those early aggressions, showing where they come from, and helping the patient work through them. I was very impressed that you have made a fine start in that direction with Louise.

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